Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

FINANCIAL/SOCIAL SERVICES COMMUNICATION

DATE

1. TO: | ORGANIZATION | MAILSTOP

FROM: | ORGANIZATION | MAILSTOP

CASE NAME | TELEPHONE NUMBER | CASE NUMBER

ADDRESS | CITY | STATE | ZIP CODE

2.

☐ Needs special assistance
☐ Limited English Proficiency

Preferred language: _____

APPLICATION

Date: _____

☐ Approved
☐ Denied
☐ Withdrawn
☐ Pending

CLIENT IS:

☐ Waiting
☐ Not waiting
☐ Needs home visit

3.

A service determination is required for:

☐ Non-grant "P" medical
☐ Child care plan
☐ JOBS
☐ CCF or NF placement
☐ COPES
☐ Protective Payee assessment
☐ Teen assessment for Protective Payee
☐ Supplemental Security Income (SSI) facilitation
☐ Other:

☐ Alcohol/drug treatment
☐ Incapacity: ☐ GA-U ☐ GA-X ☐ TANF, for: _____
☐ Chore services
☐ Medicaid personal care
☐ Additional requirements:

_____

4.

☐ Financial service determination is required for:

☐ Other: